ADULT GROWTH HORMONE[1]

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

❒ Initial request ❒ Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Patient must have one of the following primary indications listed below, confirmed by a board certified endocrinologist:

- ❒ Adult with childhood onset of growth hormone deficiency
- ❒ Adult onset of growth hormone deficiency with no other deficiencies
- ❒ Adult onset of growth hormone deficiency without other pituitary hormone deficiencies

Diagnostic testing required:

1. IGF-1 Level: _____ ng/ml Date: _____
2. Is there a contraindication to ITT[2]? ❒ Yes ❒ No
   If yes, indicate reason: _____
3. Provocative Testing: Check appropriate selection
   ❒ Adult with childhood onset GHD or with additional pituitary hormone deficits (one {1} stimulation test required)
   ❒ Adult with suspected GHD with no other pituitary hormone deficits (two {2} stimulation tests required)
   Test 1: type _____ Results: _____ng/ml Date: _____
   Test 2: type _____ Results: _____ng/ml Date: _____
4. Has the patient been screened for intracranial malignancy or tumor? ❒ Yes ❒ No (If no, request will be denied)
5. If a history of malignancy exists, have they been free of recurrence for at least the past six (6) months?
   ❒ Yes ❒ No (If no, request will be denied) ❒ No malignancy
6. Does the patient have any of the following contraindications? Check all that apply. **If any apply, deny request. If not, approve.**
   ❒ Pregnancy ❒ Proliferative or preproliferative diabetic retinopathy ❒ Pseudotumor cerebri or benign intracranial HTS

[1] Nutropin AQ®, Nutropin®, Humatrope®, Genotropin®, and Protropin®

[2] As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. If contraindicated (seizures, CAD, abnormal EKG with history of IHD or CVD, and not advised for those > age 60), documentation must be provided and an alternative test result (arginine, glucagon, growth hormone-releasing hormone {GHRH}, L-dopa and combinations of these agents, excludin clonidine) may be substituted.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments: _____

_____ _____
Reviewer's Signature Response Date/Hour